FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035048

Facility Name: Lake Shore Healthcare & Rehab Ctr

Address: 7200 North Sheridan Road (Number) Chicago (City) 60626 (Zip Code)

County: Cook

Telephone Number: (773) 973-7200 **Fax #** (773) 973-7724

HFS ID Number: 36-3690679

Date of Initial License for Current Owners: 28th July 1992

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christopher Vicere **Telephone Number:** (773) 604-4416

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1-Jan-05 to 31-Dec-05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date) 31st March 2006

(Type or Print Name) Christopher Vicere

(Title) Vice President - Finance

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	313	Skilled (SNF)	313	114,245	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	313	TOTALS	313	114,245	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,998	1,910	6,557	36,465	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	38,253	1,806	52	40,111	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	66,251	3,716	6,609	76,576	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.03%

D. How many bed-hold days during this year were paid by the Department?
None (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 1st March 1989

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 28th July 1992 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 313 and days of care provided 5,674

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/05 Fiscal Year: 12/31/05

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	414,346	76,188	45,744	536,278		536,278		536,278			1
2	Food Purchase		434,949		434,949	(36,591)	398,358	(201)	398,157			2
3	Housekeeping	287,328	129,937		417,265		417,265		417,265			3
4	Laundry	212,594	37,720	340	250,654		250,654		250,654			4
5	Heat and Other Utilities			419,858	419,858		419,858		419,858			5
6	Maintenance	177,436	80,288	315,675	573,399		573,399	(5,977)	567,422			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,091,704	759,082	781,617	2,632,403	(36,591)	2,595,812	(6,178)	2,589,634			8
	B. Health Care and Programs											
9	Medical Director			45,250	45,250		45,250		45,250			9
10	Nursing and Medical Records	4,095,979	429,327	231,837	4,757,143		4,757,143		4,757,143			10
10a	Therapy			8,248	8,248		8,248		8,248			10a
11	Activities	159,330	55,516		214,846		214,846		214,846			11
12	Social Services	154,574	5,449		160,023		160,023		160,023			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):* ***Dental Service****			6,972	6,972		6,972		6,972			15
16	**TOTAL Health Care and Programs**	4,409,883	490,292	292,307	5,192,482		5,192,482		5,192,482			16
	C. General Administration											
17	Administrative	206,740		499,548	706,288		706,288	(278,208)	428,080			17
18	Directors Fees											18
19	Professional Services			67,093	67,093		67,093	30,370	97,463			19
20	Dues, Fees, Subscriptions & Promotions			78,164	78,164		78,164	(47,657)	30,507			20
21	Clerical & General Office Expenses	217,046	80,435	81,194	378,675		378,675	118,562	497,237			21
22	Employee Benefits & Payroll Taxes			958,153	958,153	36,591	994,744	92,117	1,086,861			22
23	Inservice Training & Education			2,628	2,628		2,628	2,026	4,654			23
24	Travel and Seminar			6,469	6,469		6,469	8,700	15,169			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			19,451	19,451		19,451		19,451			26
27	Other (specify):* ***Payroll Taxes (Sch VII)****							29,786	29,786			27
28	**TOTAL General Administration**	423,786	80,435	1,712,700	2,216,921	36,591	2,253,512	(44,304)	2,209,208			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,925,373	1,329,809	2,786,624	10,041,806		10,041,806	(50,482)	9,991,324			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr #0035048 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			63,284	63,284		63,284	309,238	372,522			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			24,782	24,782		24,782	237,474	262,256			32
33	Real Estate Taxes			407,323	407,323		407,323		407,323			33
34	Rent-Facility & Grounds			845,014	845,014		845,014	(840,000)	5,014			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			1,340,403	1,340,403		1,340,403	(293,288)	1,047,115			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		558,354	731,218	1,289,572		1,289,572		1,289,572			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			171,368	171,368		171,368		171,368			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		558,354	902,586	1,460,940		1,460,940		1,460,940			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,925,373	1,888,163	5,029,613	12,843,149		12,843,149	(343,770)	12,499,379			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VI. ADJUSTMENT DETAIL **A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(62,101)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(201)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,344)	24		19
20	Contributions	(4,748)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,626)	21		24
25	Fund Raising, Advertising and Promotional	(90,001)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(3,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(484)	20		28
29	Other-Attach Schedule **Per page 5A attached**	(5,977)	6		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (198,482)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(145,288)	6 & 6A	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (145,288)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (343,770)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS **Page 5A**

Lake Shore Healthcare & Rehab Ctr

ID# **0035048**

Report Period Beginning: **1-Jan-05**

Ending: **31-Dec-05**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance Expenses (incurred in 2005)	$ (10,961)	6	1
2	Deferred Maintenance Exps (allocated for 2005)	4,984	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(5,977)		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr **#** 0035048 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(201)	0	0	0	0	0	0	0	0	0	0	(201)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,977)	0	0	0	0	0	0	0	0	0	0	(5,977)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,178)	0	0	0	0	0	0	0	0	0	0	(6,178)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(278,208)	0	0	0	0	0	0	0	0	0	(278,208)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	30,370	0	0	0	0	0	0	0	0	0	30,370	19
20	Fees, Subscriptions & Promotions	(95,233)	47,576	0	0	0	0	0	0	0	0	0	(47,657)	20
21	Clerical & General Office Expenses	(30,626)	146,188	3,000	0	0	0	0	0	0	0	0	118,562	21
22	Employee Benefits & Payroll Taxes	0	92,117	0	0	0	0	0	0	0	0	0	92,117	22
23	Inservice Training & Education	0	2,026	0	0	0	0	0	0	0	0	0	2,026	23
24	Travel and Seminar	(4,344)	13,044	0	0	0	0	0	0	0	0	0	8,700	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	29,786	0	0	0	0	0	0	0	0	0	29,786	27
28	**TOTAL General Administration**	(130,203)	82,899	3,000	0	0	0	0	0	0	0	0	(44,304)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(136,381)	82,899	3,000	0	0	0	0	0	0	0	0	(50,482)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr **#** 0035048 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(62,101)	943	370,396	0	0	0	0	0	0	0	0	309,238	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	69,660	167,814	0	0	0	0	0	0	0	0	237,474	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(840,000)	0	0	0	0	0	0	0	0	(840,000)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(62,101)	70,603	(301,790)	0	0	0	0	0	0	0	0	(293,288)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(198,482)	153,502	(298,790)	0	0	0	0	0	0	0	0	(343,770)	45

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Officers' Salaries	$	Lancaster, Ltd.	100.00%	$ 152,132	$ 152,132	1
2	V	27	Payroll Taxes-Officers		Lancaster, Ltd.	100.00%	29,786	29,786	2
3	V	17	Management Fee Income	499,548	Lancaster, Ltd.	100.00%		(499,548)	3
4	V	19	Professional Services		Lancaster, Ltd.	100.00%	30,370	30,370	4
5	V	21	Clerical Expenses		Lancaster, Ltd.	100.00%	146,188	146,188	5
6	V	22	Employee Benefits		Lancaster, Ltd.	100.00%	92,117	92,117	6
7	V	24	Seminars & Travel		Lancaster, Ltd.	100.00%	13,044	13,044	7
8	V	17	Administrative Consulting		Lancaster, Ltd.	100.00%	69,208	69,208	8
9	V	20	Marketing and Fees		Lancaster, Ltd.	100.00%	45,316	45,316	9
10	V	32	Interest	24,782	Lancaster, Ltd.	100.00%	94,442	69,660	10
11	V	30	Depreciation		Lancaster, Ltd.	100.00%	943	943	11
12	V	20	Dues, Fees and Subscriptions		Lancaster, Ltd.	100.00%	2,260	2,260	12
13	V	23	Education & Inservice		Lancaster, Ltd.	100.00%	2,026	2,026	13
14	Total			$ 524,330			$ 677,832	$ * 153,502	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V		34	Rental Income	$ 840,000	Lake Shore Associates		$	$ (840,000)	15
16	V		30	Depreciation		Lake Shore Associates		370,396	370,396	16
17	V		32	Interest	96,149	Lake Shore Associates		263,963	167,814	17
18	V		21	State Replacement Tax		Lake Shore Associates		3,000	3,000	18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 936,149			$ 637,359	$ * (298,790)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Laurence Zung	Executive Officer	Administrative	45%	See Attached	14	29.17%	Lancaster	$ 61,250	17-7	1
2	Christopher Vicere	VP-Finance	Administrative	5%	See Attached	13	27.08%	Lancaster	45,441	17-7	2
3	Cheryl Morris	VP-Operations	Administrative	5%	See Attached	13	27.08%	Lancaster	45,441	17-7	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 152,132		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Lancaster, Ltd.
Street Address: 5061 N. Pulaski Road
City / State / Zip Code: Chicago, IL 60630
Phone Number: (773)604-4416
Fax Number: (773)478-1192

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Laurence Zung	Hours Worked	48	7	$ 210,000	$ 210,000	14	$ 61,250	1
2	27	Laurence Zung-payroll tax	Hours Worked	48	7	9,553		14	2,786	2
3	17	Christopher Vicere	Hours Worked	48	7	167,782	167,782	13	45,441	3
4	27	Christopher Vicere-payroll tax	Hours Worked	48	7	8,941		13	2,422	4
5	17	Cheryl Morris	Hours Worked	48	7	167,782	167,782	13	45,441	5
6	27	Cheryl Morris-payroll tax	Hours Worked	48	7	8,941		13	2,422	6
7										7
8										8
9										9
10										10
11										11
12										12
13	19	Professional Services	Management Fees	2,140,820	7	130,152		499,548	30,370	13
14	21	Clerical Expenses	Management Fees	2,140,820	7	626,489	553,344	499,548	146,188	14
15	22	Employee Benefits	Management Fees	2,140,820	7	394,769		499,548	92,117	15
16	24	Seminars & Travel	Management Fees	2,140,820	7	55,902		499,548	13,044	16
17	17	Administrative Consulting	Management Fees	2,140,820	7	296,590	296,590	499,548	69,208	17
18	20	Marketing and Fees	Management Fees	2,140,820	7	194,202	180,270	499,548	45,316	18
19	32	Interest	Management Fees	2,140,820	7	(7,314)		499,548	(1,707)	19
20	30	Depreciation	Management Fees	2,140,820	7	4,042		499,548	943	20
21	20	Dues, Fees and Subscriptions	Management Fees	2,140,820	7	9,684		499,548	2,260	21
22	27	Payroll Taxes	Management Fees	2,140,820	7	94,951		499,548	22,156	22
23	23	Education & Inservice	Management Fees	2,140,820	7	8,681		499,548	2,026	23
24	32	*Direct Interest*							96,149	24
25	TOTALS					$ 2,381,147	$ 1,575,768		$ 677,832	25

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	JP Morgan Chase Bank		X	Commercial Loan	$30,000.00	5/1/02	$ 7,200,000	$ 6,330,000		4.8900%	$ 263,963	1
2												2
3												3
4												4
5												5
	Working Capital											
6	JP Morgan Chase Bank		X	Working Capital							(1,707)	6
7												7
8												8
9	TOTAL Facility Related				$30,000.00		$ 7,200,000	$ 6,330,000			$ 262,256	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 7,200,000	$ 6,330,000			$ 262,256	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # N/A

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr **#** 0035048 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	397,900	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	398,723	2
3. Under or (over) accrual (line 2 minus line 1).	$	823	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	406,500	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	407,323	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	416,205	8
2001	427,029	9
2002	431,817	10
2003	390,059	11
2004	398,723	12

** Accrual is based on 2004 actual Taxes, adjusted for inflation**

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lake Shore Healthcare & Rehab Ctr COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0035048

CONTACT PERSON REGARDING THIS REPORT Christopher Vicere

TELEPHONE (773) 604-4416 FAX #: (773) 478-1192

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A)	(B)	(C)	(D)
	Tax Index Number	**Property Description**	**Total Tax**	**Tax Applicable to Nursing Home**
1.	11-29-320-035-0000	Long-Term Healthcare	$ 26,344.03	$ 26,344.03
2.	11-29-320-036-0000	Long-Term Healthcare	$ 86,330.85	$ 86,330.85
3.	11-29-320-037-0000	Long-Term Healthcare	$ 86,803.79	$ 86,803.79
4.	11-29-320-038-0000	Long-Term Healthcare	$ 86,803.79	$ 86,803.79
5.	11-29-320-039-0000	Long-Term Healthcare	$ 86,616.65	$ 86,616.65
6.	11-29-320-040-0000	Long-Term Healthcare	$ 25,824.18	$ 25,824.18
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 398,723.29	$ 398,723.29

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,769 B. General Construction Type: Exterior Brick Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1			1992	$ 740,000	1
2					2
3	TOTALS			$ 740,000	3

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	313		1992		$ 11,667,460	$ 370,396	40	$ 291,687	$ (78,709)	$ 3,937,775	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1989	24,908		10			24,908	9
10	Various			1990	80,814		10			80,814	10
11	Various			1991	28,469	3,279	20	1,112	(2,167)	22,673	11
12	Various			1992	12,856	408	20	643	235	8,643	12
13	Various			1993	68,862	1,789	20	3,444	1,655	43,045	13
14	Various			1994	5,698	146	20	286	140	3,379	14
15	Various			1995	76,433	1,767	20	3,822	2,055	40,932	15
16	Fire Alarm System			1996	54,450	1,396	20	2,723	1,327	27,230	16
17	Seamco Stone Deck			1996	7,989	205	20	399	194	3,724	17
18	Roof Exhauster			1996	2,700	69	20	135	66	1,237	18
19	Front Sign			1996	12,020	710	20	601	(109)	5,559	19
20	Water Heating System			1997	38,800	995	20	1,940	945	17,137	20
21	Fluorescent Conversion			1997	25,353	650	20	1,268	618	11,095	21
22	Elevator Improvement			1998	55,364	1,420	20	1,420		10,828	22
23	Electronic Alzheimer Doors			1998	11,800	303	20	303		2,209	23
24	Elevator Interiors			1999	34,422	883	20	883		5,629	24
25	Parking Lot Resurface			1999	20,240	1,195	20	1,195		9,633	25
26	Patio Stone Decking			1999	6,465	382	20	382		3,173	26
27	Electric Panel Board			2002	5,000	128	10	500	372	1,667	27
28	Parking Lot Fence			2003	19,707	842	10	1,314	472	3,449	28
29	Hand Rail System			2005	5,968	109	10	448	339	448	29
30	Wood Flooring			2005	4,248	77	10	319	242	319	30
31	Concrete Patio Porch			2005	8,603	138	10	574	436	574	31
32	Piping For Hot Water System			2005	11,900	166	10	694	528	694	32
33	Eclipse Gas Booster			2005	9,000	125	10	525	400	525	33
34	Wallguards			2005	2,519	30	10	126	96	126	34
35	Electrical Sub Panel			2005	3,370	32	10	140	108	140	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Concrete Work at Drain	2005	$ 1,595	$ 12	10	$ 53	$ 41	$ 53	37
38	Heaters in Outdoor Patio	2005	2,850	9	10	48	39	48	38
39	Junction Box - Fire Panel	2005	780	3	10	13	10	13	39
40	Electricals for 12 Bedrooms	2005	1,600	5	10	27	22	27	40
41	Electricals for 6 Bedrooms	2005	800	1	10	7	6	7	41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 12,313,043	$ 387,670		$ 317,031	$ (70,639)	$ 4,267,713	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 636,843	$ 24,990	$ 41,756	$ 16,766		$ 127,121	71
72	Current Year Purchases	65,602	10,275	4,371	(5,904)		4,371	72
73	Fully Depreciated Assets	1,766,787	10,745	8,421	(2,324)		1,766,787	73
74	**Lancaster Allocation**		943	943			7,458	74
75	TOTALS	$ 2,469,232	$ 46,953	$ 55,491	$ 8,538		$ 1,905,737	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 15,522,275	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 434,623	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 372,522	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (62,101)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 6,173,450	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: **N/A -- Related Party Lease**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5		** Off-site Public Storage space **			5,014			5
6								6
7	TOTAL				$ 5,014 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 163,446	$		$ 163,446	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			16,253			16,253	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			201,874			201,874	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation *Ventilation Therapy*	39-3 & 39-2	hrs			349,645	61,968		411,613	8
9	Pharmacy	39-2	# of prescrpts				247,299		247,299	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	**Medical Supplies**	39-2					94,434		94,434	13
	Other (specify): **Specialty Beds**	39-2					154,653		154,653	
14	TOTAL			$		$ 731,218	$ 558,354		$ 1,289,572	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr **#** 0035048 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 31-Dec-05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 58,086	$ 58,086	1
2	Cash-Patient Deposits	90,866	90,866	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	4,138,173	4,138,173	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	82,081	82,081	6
7	Other Prepaid Expenses	12,361	12,361	7
8	Accounts Receivable (owners or related parties)	31,681	2,354,554	8
9	Other(specify): **Refundable Deposits**	1,775	1,775	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 4,415,023	$ 6,737,896	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		740,000	13
14	Buildings, at Historical Cost		11,667,460	14
15	Leasehold Improvements, at Historical Cost	607,190	611,190	15
16	Equipment, at Historical Cost	1,200,953	2,469,232	16
17	Accumulated Depreciation (book methods)	(1,255,322)	(7,512,514)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		217,904	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(217,904)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): *Construction-in-Progress*	2,235	389,885	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 555,056	$ 8,365,253	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,970,079	$ 15,103,149	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 376,331	$ 400,332	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	90,866	90,866	28
29	Short-Term Notes Payable	2,517,603	2,517,603	29
30	Accrued Salaries Payable	708,392	708,392	30
31	Accrued Taxes Payable (excluding real estate taxes)	23,594	23,594	31
32	Accrued Real Estate Taxes(Sch.IX-B)	406,500	406,500	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,123,286	$ 4,147,287	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		6,330,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 6,330,000	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,123,286	$ 10,477,287	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 846,793	$ 4,625,862	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,970,079	$ 15,103,149	48

***(See instructions.)**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ (948,635)	1	
2	Restatements (describe):		2	
3	**Adjustment for Tax Refund Prior Years**	(5,844)	3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (954,479)	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	(1,114,840)	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants	3,101,112	11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe) ** Treasury Stock **	(185,000)	15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,801,272	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 846,793	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVI. STATEMENT OF CHANGES IN EQUITY

		Total after Consolidation	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,920,918	1
2	Restatements (describe):		2
3	**Adjustment for Tax Refund Prior Years**	(5,844)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,915,074	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(816,050)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	4,076,838	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **TreasuryStock**	(550,000)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,710,788	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,625,862	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 11,887,567	1
2	Discounts and Allowances for all Levels	(1,820,646)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,066,921	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,161,404	6
7	Oxygen	147,750	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,309,154	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	227,374	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,635	19
20	Radiology and X-Ray	9,255	20
21	Other Medical Services	105,970	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 346,234	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	**Vending Commissions**	6,000	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,000	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 11,728,309	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,632,403	31
32	Health Care	5,192,482	32
33	General Administration	2,216,921	33
	B. Capital Expense		
34	Ownership	1,340,403	34
	C. Ancillary Expense		
35	Special Cost Centers	1,289,572	35
36	Provider Participation Fee	171,368	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 12,843,149	40
41	**Income before Income Taxes (line 30 minus line 40)****	(1,114,840)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (1,114,840)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. **Cash Basis Taxpaye**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,046	2,086	$ 72,502	$ 34.76	1
2	Assistant Director of Nursing	1,947	2,183	74,946	34.33	2
3	Registered Nurses	64,973	69,393	1,727,711	24.90	3
4	Licensed Practical Nurses	11,238	12,371	278,397	22.50	4
5	CNAs & Orderlies	161,897	175,365	1,848,901	10.54	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	5,628	6,228	81,081	13.02	9
10	Activity Assistants	7,302	7,884	78,249	9.93	10
11	Social Service Workers	10,585	11,519	154,574	13.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	38,872	41,888	414,346	9.89	15
16	Dishwashers					16
17	Maintenance Workers	12,568	13,750	177,436	12.90	17
18	Housekeepers	28,489	31,902	287,328	9.01	18
19	Laundry	22,064	24,564	212,594	8.65	19
20	Administrator	1,885	2,263	94,597	41.80	20
21	Assistant Administrator	4,544	4,930	112,143	22.75	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	12,227	13,600	217,046	15.96	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,332	7,997	93,522	11.69	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	393,597	427,923	$ 5,925,373 *	$ 13.85	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	1,430	$ 45,744	1-3	35
36	Medical Director	945	45,250	9-3	36
37	Medical Records Consultant	117	4,224	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	471	8,578	10-3	39
40	Physical Therapy Consultant	231	8,248	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	3,194	$ 112,044		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	6,220	$ 156,104	10-3	50
51	Licensed Practical Nurses	2,170	62,931	10-3	51
52	Certified Nurse Assistants/Aides				52
53	TOTAL (lines 50 - 52)	8,390	$ 219,035		53

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
James R. Farlee (effective 4/22/05)	Administrator	N/A	$ 64,614
Merville Villa (through 4/22/05)	Administrator	N/A	29,983
Judith M. Lewis	Asst. Admn.	N/A	61,141
Joanne Ventrella (through 6/20/05)	Asst. Admn.	N/A	22,058
Abraham Mathew (through 2/12/05)	Asst. Admn.	N/A	4,812
Ushas Mathew (effective 4/7/05)	Asst. Admn.	N/A	24,132
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 206,740

B. Administrative - Other

Description	Amount
Management Fees - Lancaster	$ 499,548
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 499,548

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg/Richard Peelo	Accounting	$ 4,335
Winston & Strawn/Pat Hogan	Legal	635
Stone, Pogrund & Korey	Legal	30,104
Gaffarelli & Seigel Ltd	Legal	11,069
Donald Schultz	Legal	800
Amedeo Greco	Legal	1,468
Accu-Med Services, Inc.	Data Processing	4,200
MediFax EDI Inc./Adminastar	Data Processing	831
Emdeon Business/@Datanet	Data Processing	420
Health Data Systems, Inc.	Data Processing	6,192
E Health Data Solutions	Data Processing	4,675
Personnel Planners	Payroll Tax Consultant	2,364
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 67,093

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 108,942
Unemployment Compensation Insurance	59,270
FICA Taxes	445,979
Employee Health Insurance	275,528
Employee Meals	36,591
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	9,052
Misc. Employee Benefits	32,937
Retirement Plan Contributions	11,946
Holiday expenses	5,055
Employment Fees	9,444
Lancaster Allocation	92,117
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,086,861

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
N/A		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	8,660
Health Care Worker Background Check	1,470
(Indicate # of checks performed 98)	
Promotional Advertising	54,185
Yellow Pages Advertising	484
Licenses & Fees	7,882
Dues & Subscription	3,493
Lancaster Allocation	47,576
Less: Public Relations Expense	(39,933)
Non-allowable advertising	(54,816)
Yellow page advertising	(484)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 30,507

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	599
Seminar Expense	5,870
Lancaster Allocation	13,044
Entertainment Expense	(4,344)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 15,169

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr # 0035048 Report Period Beginning: 1-Jan-05 Ending: 31-Dec-05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1	Painting and Decorating	Aug-2001	$ 674	3	$ 224	$ 224	$ 113	$	$	$	$	$	$
2	Painting and Decorating	Dec-2001	1,199	3	400	400	199						
3	Painting and Decorating	Jul-2002	113	3	20	37	37	19					
4	Painting and Decorating	Aug-2002	1,252	3	209	417	417	209					
5	Painting and Decorating	Nov-2002	229	3	39	76	76	38					
6	Painting and Decorating	Jan-Mar '03	664	3		111	221	221	111				
7	Painting and Decorating	Jul-Sept '03	1,012	3		168	338	338	168				
8	Painting and Decorating	Oct-Dec '03	1,401	3		234	467	467	233				
9	Painting and Decorating	Jan-Jul '04	1,320	3			220	440	440	220			
10	Painting and Decorating	Aug-Oct'04	1,507	3			251	502	502	252			
11	Painting and Decorating	Nov-Dec '04	2,768	3			461	923	923	461			
12	Painting and Decorating	Jan-Jun '05	8,457	3				1,410	2,819	2,819	1,409		
13	Painting and Decorating	Jul-Dec '05	2,504	3				417	835	835	417		
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 23,100		$ 892	$ 1,667	$ 2,800	$ 4,984	$ 6,031	$ 4,587	$ 1,826	$	$

Facility Name & ID Number Lake Shore Healthcare & Rehab Ctr **#** 0035048 **Report Period Beginning:** 1-Jan-05 **Ending:** 31-Dec-05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **56,065** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **171,368**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **36,591** Has any meal income been offset against related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.